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ABSTRACT

The future of nursing is discussed in these five papers delivered at a symposium in honcr of Jessie M. Scott, Director of the Divisicn of Nursing, U.S. Department of Health and Human Services, 1964-1979. In the first article, "Old Dreams--New Visions," Virginia Cleland reviews the economics of medicine and calls for a new Surgeon General's Report to guide the development cf public/professional relationships in nursing, especially the issue of reimbursing nursing services separately from the general hospital bill. The seccnd article, "Toward 1999: Probing Ethical Dilemmas in Nursing's Future," is Mila A. Aroskar's analysis of the concept of justice and ethical issues in health care decisions. In the third paper, "Social and Economic Issues," Luther Christman warns that the level of nursing education must be drastically raised to keep nursing an equal of the other health care professions. The fourth article, "Forces for Forecasting: Biological-Environmental Issues," by Cornelius Kruse, states that envircnmental regulations must be based cn scientific fact and subject to years of research. The final article, "Forces for Forecasting: Crganizational Issues," by Dorothy J. Novello, describes the current state of the health care delivery system and poses questions for the future of the nursing profession. (KC)

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Prospectives for Nursing: A Symposium

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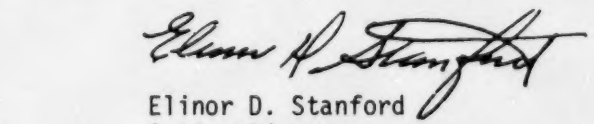
No.14 A Classification Scheme for Client Problems in Community Health Nursing

FOREWORD

We live in an age of constantly changing science and technology. These changes have always had, and will continue to have a critical impact on nursing. As stated by Dr. Ruth B. Freeman, Professor Emeritus, The Johns Hopkins School of Hygiene and Public Health, "Nursing will grow from its own historical antecedents, from broad socio-economic-ethical trends that affect all human services, from biological and environmental threats that determine the focus of health efforts, and from the organizational systems through which health resources are applied to human problems."

While we celebrate the progress of nursing in the past, we also keep a keen eye on the issues for the future. A symposium to explore and discuss these issues was held on May 25, 1979, in honor of Jessie M. Scott, Director of the Division of Nursing from 1964 to 1979. The symposium, "Prospectives for Nursing," was particularly appropriate as an honor for Miss Scott since her achievements embodied the best of the past, and her leadership over the years provided a bright outlook for the future of nursing.

The papers presented at the symposium, and published here for a wider audience, cover a broad range of social, ethical, economic, and technical issues impinging on the future of the profession. We are indebted to Dr. Virginia Cleland, Dr. Mila Aroskar, Dr. Luther Christman, Dr. Cornelius Kruse, and Dr. Dorothy Novello for their papers. Dr. Kruse kindly participated on very short notice. We are further indebted to Miss Jo Eleanor Elliott, who moderated a panel discussion, "Nursing 1999: Forces for Forecasting."



Elinor D. Stanford
Acting Director
Division of Nursing

CONTENTS

Prospectives for Nursing: Old Dreams, New Visions
Virginia Cleland, Ph.D. 1

Toward 1999: Probing Ethical Dilemmas in Nursing's Future
Mila A. Aroskar, Ph.D. 11

Prospectives for Nursing: Social and Economic Issues
Luther Christman, R.N., Ph.D. 17

Prospectives for Nursing: Forces for Forecasting: Biological and Environmental Issues
Cornelius Kruse, Dr.PH 21

Prospectives for Nursing: Forces for Forecasting: Organizational Issues
Dorothy J. Novello, Ph.D. 25

PROSPECTIVES FOR NURSING
OLD DREAMS - NEW VISIONS

Virginia Cleland, Ph.D.

The occasion of the retirement of Jessie M. Scott, Assistant Surgeon General, PHS, and Director of the Division of Nursing for the past 15 years, provides an opportunity to reflect on the future of nursing. We have gathered here today to honor our good friend and colleague, Jessie Scott, by participating in this symposium.

The title suggested by the planning committee for my paper is "Old Dreams - New Visions." We dream of nursing being recognized for providing significant services in health promotion, illness prevention, diagnosis and treatment of health-related problems, and care of the ill, injured, and dying. We dream of recognition and financial remuneration (and these are important), but more significantly we dream of greater autonomy and accountability in the practice of nursing. We dream that with the appropricte use of nurses, by level of education and experience, nursing can have a significant effect on the availability, accessibility, acceptability, continuity, quality, and cost of health services. On clear days--when I can see forever--I know that none of these health system goals can be accomplished without active participation and commitment from nursing.

While a dream is a creation of the imagination, a vision is an object of imagination, a way of seeing something or conceiving an idea. A vision represents unusual discernment or foresight--a new way of perceiving phenomena.

My paper deals, then, with the visions I perceive of nursing at this time. I have no unusual foresight except that I personally enjoy trying to see nursing within the broader context of the total health system. You will judge, and time will tell us, whether I am describing merely old dreams or new visions.

With the congressional authority for the Nurse Training Act due to expire, it is time for a new Surgeon General's Report to be prepared by a consultant committee composed of members from the nursing profession, the public, and relevant governmental bureaus. Nursing, governmental officials, and the public need a position paper of the nature of the 1963 Surgeon General's Report to provide clarification of these complex public and professional relationships and to delineate what the Federal role should be in achieving new goals.

Certainly, an essential aspect of a newly commissioned paper would be health economics. Nurses have not usually been in a position to examine the economic relationships of the health industry and often, as individuals, have

preferred not to be involved. Nurses are human service practitioners, but their services are provided in a world controlled by economics. The economic rules and regulations are quite predictive of who gets what service from which type of practitioner in what facility, for example:

Welfare class--interns and residents, public hospitals
Working class--general and family practitioners, private community hospitals
Upper middle class--board-certified specialists, private teaching hospitals

It is no accident that medical students and house officers learn their techniques on welfare patients. These relationships are economically determined and have little to do with "service" attitudes and "caring" philosophies of individual practitioners. As an illustration, it may be helpful to look at some Medicare-Medicaid reimbursement regulations.

Medicine, the profession that meets all the sociologists' criteria for a "profession," practices great subtlety, economically. Physicians through the Political Action Committee of the American Medical Association are repeatedly the largest contributors to the election campaigns of Members of Congress. In return for this continuing largess, Congress instructed Social Security Administration to designate physician fees under Medicare-Medicaid legislation to be the "prevailing and customary" charges currently being paid (1).

The physician is reimbursed on the basis of the lowest of (1) his actual charge, (2) his customary charge, or (3) the areas's prevailing charge. The actual charge is self-explanatory. The customary charge is the physician's median billed charge for that service during the previous calendar year. The prevailing charge may be the 75th percentile of the distribution of all customary charges by "similar" physicians within a geographic market area. Under Blue Cross the prevailing charge is set at the 90th percentile and commercial insurers pay at the 92nd percentile of the prevailing charges (2).

Thus, under the rubric of "customary and usual" fees the physician can charge any fee he wishes and then actually collect a fee set at 90 percent of those customary in that locality. The difference between the actual and the customary can be billed directly to the patient. In the case of the elderly, employed children often step forward to pay "the uncovered" portion of mother's bill which was not paid by Medicare. But even if the excess charge is never collected, it goes into next year's computations of that physician's "customary" charges and that community's "usual" fee for that particular service.

We see anesthesiologists sending professional service bills to patients whose anesthetic was given by a nurse anesthetist. Thus the patient, or his insuring party, may pay twice for the same procedure--once as a part of the hospital bill since the nurse anesthetist most frequently receives a hospital-based salary and secondly, in a professional service bill from the anesthesiologist. It would be appropriate for the anesthesiologist to be paid a salary for this administrative and supervisory function, but a professional fee for service per patient hardly can be justified.

Radiologists and pathologists negotiate percentages of those departments' gross or net receipts. Are patients paying for professional services as "piece work" or should these be called "commissions?"

Hospital administrators stand behind their institution's nonprofit status and view their institution as a community resource. In truth, an institution may be offering duplicative services which add unnecessarily to health service costs in that area. Many hospitals in this Nation have board members who are in direct conflict of interest because of economic relationships with the institution. An attorney may sit on the hospital board while his partner handles the institution's legal or labor contracts. The president of the local bank may sit on the board and the hospital keeps its accounts in that bank or that bank loans the hospital money for a new facility. I believe so-called nonprofit hospital board members should be required to sign annual statements that they have no personal or family economic interest in the financial future of the institution.

Nonprofit status in most States sets no limits on administrator's salaries but rather only restricts the disbursement of net receipts to avoid showing a profit. Thus, all over the country, hospitals have expanded their physical plants, added new services and have built medical office facilities for physicians who agree to bring their patients for hospitalization in that hospital. Few of these buildings are charged the usual property taxes. Hospitals, like physicians, have been treated very generously in Medicare/Medicaid legislation. Claiborne has reported,

> "Social Security Administration allowed hospitals to depreciate the full cost of buildings that had already been partly, or even wholly, depreciated. They could depreciate buildings constructed with federal grants--meaning that the government was paying twice for the same building. They could write off the cost of equipment well before its useful term of life. And so on.
>
> "Perhaps most important, hospitals were not required to 'fund' their depreciation allowances, to actually set them aside for use only in replacing obsolete plants. Instead, they could (and did) use the funds for additional buildings and equipment - whose 'reasonable costs' then became a ground for demanding still higher government payments." (3)

Hospitals which are frankly incorporated as for-profit institutions tend to be more honest in their goals. The for-profit hospitals skim hospital admissions which are short-term and highly predictable and where bills will be fully paid, and then send the complex, long-term, inadequately financed patients to tax-supported institutions. With inflation and tax limitations due to referenda, public institutions, particularly city and county hospitals, are closing. These institutions have limited income and very high costs because they are left with the patients other hospitals do not want to admit.

The hospital-medical complex is the third largest employer in the United States, exceeded only by government (local, State, and Federal) and the wholesale-retail industry. It is a very complex, very expensive, interrelated nonsystem. How does such a nonsystem hang together enough to be commonly referred to as "the health system?" There is one common rule that explains more health system behavior than all the theories taught in schools of nursing. This rule is that hospital administrators, singly or as a group, never take a position which places them between a physician and his ability to make money. The first corollary of the rule is that a physician never places himself between a hospital administrator and that institution's ability to make money. Thus, it becomes very difficult for health planners and economists to get all the information needed for decisions compatible with the public welfare.

The spiraling costs of health services cannot be controlled without legal restrictions involving the practice of medicine. Physicians initiate nearly all health service charges.

At one time it was thought physicians were like other economic commodities. If society increased the number of physicians, some would establish their practices in rural areas and in the center of urban cities and thus correct the problems of maldistribution. More recent studies indicate that this is not a valid assumption. The health system economy does not respond as a normal market for several reasons: (1) uninformed consumers--consumers do not have the requisite information on which to make informed judgments about the services to be purchased; (2) control of demand by providers--the patient generally makes only one decision, that is, to seek medical care; (3) third party payment of medical hospital bills--70 percent of all services are paid by a third party so the patient is not concerned about the size of the bill and the physician is assured reimbursement; (4) cost-based retrospective reimbursement--nonprofit hospitals have been rewarded both in prestige and financially for being large and having a wide range of services rather than being well-managed and efficient (3).

As the economic relation of physicians, medical services, and hospitals has become better understood, there have been two general policy reversals in recent years. After 30 years of federally financed hospital construction and modernization, there is general agreement that the Nation has too many hospital beds, and policies now relate to the concept of "overbedding." With excess beds there is an unfortunate tendency to create patients to fill them.

The other policy reversal relates to physician manpower. The goal had been to increase the number of physicians to improve their distribution geographically and by specialty, that is, to increase the numbers in primary care practice. Undoubtedly there was also some thought that increasing the number of physicians might decrease the fees. However, economic studies now show that where physician density is high, fee levels remain high; there are increases in elective surgery, and higher levels of patient visits per hour--all of which produce a near parity in income. The policy of increasing medical school enrollments seems to have been reversed. Secretary Joseph Califano acknowledged this year before the annual meeting of the Association of American Medical Colleges that the Nation may face an oversupply of

physicians and that HEW now will seek ways to encourage medical schools to reduce enrollments (4).

A 1978 publication on the supply and distribution of physicians prepared by the Division of Medicine of HEW states, "Between 1963-1976 ... despite a 33 percent increase in total MD's, the most significant trend in MD specialty distribution has been the decline in numbers of physicians in general practice" (5). While there are now 5,400 residents in family practice, this greatly overstates the number of physicians entering these fields because, with the termination of internships in the United States, many medical school graduates are electing a first-year residency in primary care before entering subspecialties. Repeatedly those associated with medical schools report that family practice departments have the lowest status, which is not conducive to increased recruiting. More importantly, many doctors faced with a choice of postgraduate experience anticipate the same personal limitations that originally led physicians to elect to specialize. They want to be competent physicians. These are persons who are accustomed to viewing themselves as first rate, and the territory of family practice is too broad and the knowledge base is too extensive for one mind to maintain such comprehensive expertise.

I believe that organized medicine is very worried about that profession's inability to meet its manpower needs in primary health care. It is relevant to review the recommendations of a recent study by the National Academy of Science's Institute of Medicine titled A Manpower Policy for Primary Health Care (6). That report recommended equal reimbursement for equal services without regard for who provided the service.

The concept of equal reimbursement for equal service would mean that primary care physicians would be entitled to the same fee-for-service as board-certified physician specialists. The report also recommended that the differential between primary care procedures and nonprimary care procedures be reduced and that geographic differentials (which have favored urban practice) be eliminated. These changes in reimbursement policies would make primary care practice much more attractive economically to young physicians. Today, primary care physicians must see many more patients to generate the same level of income.

The Institute of Medicine's goal is to sweeten the economic pot to make primary care more attractive to physicians currently seeking the rewards of specialty practice. It would also simultaneously reduce the numbers of physicians in specialty practice, which is an economic plus for the public. However, if this policy proposal is implemented, it would greatly increase the cost of primary care in this country since all primary care would be rendered at specialty practice rates.

The persons developing the Institute of Medicine's paper also must know that equal reimbursement would make the utilization of nonphysician practitioners much less attractive to health system economists and planners concerned with controlling health care costs. If fees were to be the same, the only advantage of nonphysician providers might be availability.

For an added bestowment, there is a recommendation in the paper that States' licensure laws be amended to permit nurse practitioners to make medical diagnoses and to prescribe drugs when appropriate, but only under medical supervision. Thus, the Institute is saying to the primary care physician, "Your fees can be the same as those of specialists; you may also charge the same fees for services provided by nonphysician providers, but they must work under your supervision. You will sign the service claim form to prove you provided supervision. You may personally attend to fewer patients, generate greatly increased income, remain in complete control, and have no fear of competition. Now, wouldn't you like to be a primary care physician?"

What is the real significance of the recommendations in the Institute's paper on primary care? Some may label me naive, but I think organized medicine is very alarmed about the course of Federal health policy development. These physicians are willing to advocate a policy which would produce greatly increased primary health care costs at a time when there is increasing public concern that health care costs are too high already. They will support this policy because it offers a chance for independent physicians to retain control of all health services. Each year of delay in meeting primary service needs causes more health planners and consumers to propose alternatives. Without this gamble, the Rural Clinics Services Act suggests that many physicians will be utilized in a supervisory capacity over extended clinics, which eventually may lead to a salary for supervision rather than direct collection of fees for services. The gamble is that the public will ignore the increased cost as long as there is reasonably good insurance coverage and availability of services.

With this overview of some of the economic relationships of the health system, I would like to turn now to nursing. What has been happening? What might the future hold?

The advances of nursing during the past 15 years have been inextricably tied to the Nurse Training Act (NTA), which was first approved by Congress in 1964. The period of history of the NTA coincides almost perfectly with that of the Medicare/Medicaid legislation of 1965, so this has been a period of great change in the health system.

The NTA made possible enormous growth in nursing. Although the Act essentially fostered the education of more nurses, it has had more far reaching effects than the quantitative ones. The awarding of predoctoral fellowships by the Division of Nursing predates the NTA, and now the Nursing Research Service Awards program is a direct outgrowth. The Faculty Research Development Grants were essential for the early development of nursing research. The Special Project Grants provided monies for development costs of new activities. Construction grants gave many schools a physical plant. The quality of facilities in schools of nursing has improved immeasurably, and nursing has become a recognized discipline within universities.

The rapid growth, clinically, of the use of the nursing process (systematic problem solving) and development of health history and physical assessment skills has enabled nurses to organize their practice relationships with

clients in far more meaningful ways professionally. It is no accident that the practitioner movement and the women's movement have occurred in the same decade. Converts to both have found themselves acquiring a new selfhood. Primary care in ambulatory settings originally evolved as experiments to assist physicians to meet primary care needs of their office clientele, but it was soon found that nurse practitioners added their own dimensions of care.

Nurse practitioners were found to expand service, order fewer costly procedures, provide more health education, produce high levels of patient satisfaction, to be sensitive to whole families and the relation of health needs and care to the total age spectrum, and to be employable for half the price of a beginning physician. Never has a social experiment been so successful and expansion so limited.

This period of the greatest professional growth in our history has also brought problems. There are enormous differences in the practice competencies of registered nurses. This issue is of great concern to nurses and their employers. The profession is approaching the problem in several ways. These include (1) the credentialing study recently released by the American Nurses' Association, (2) the resolutions of the 1978 House of Delegates which relate to "entry into the practice," and (3) the proposed change of some States' licensure laws. These are all interrelated and the resolution of each affects the other.

Nursing has, over the years, developed a modified ladder system of education which permits students to make early or late decisions about professional practice. Where the largest numbers are needed, at the assisting and associate levels, the costs have been kept reasonably modest. The general pattern of 2-4-6-8 years and an AD, BSN, MSN and Ph.D permits flexibility for a variety of work-study options compatible with a society which believes in equality of opportunity and upward mobility. Included within every BSN program should be a mechanism whereby admissible graduates of 2-year programs could be accepted and graduated in about 2 calendar years with educational experiences meaningful in relation to previous learning. A clearer delineation of the goals of AD programs in relation to psychomotor skills could provide employers with graduates possessing more technical competencies. The use of vocational education funds for the teaching of these skills and improved techniques for credit validation would facilitate movement between AD and BSN programs by AD graduates. AD programs cannot be viewed as terminal (7). It is an unwarranted practice of many baccalaureate programs to fail to accommodate graduates of associate degree and diploma programs.

Nursing has the responsibility to define, clarify, and interpret for the public the levels of nursing care and the requisite academic and experiential qualifications of nurses to provide this care. Then there must be opportunity for individual nurses to progress from one level of practice to another according to individual choice and with recognition of the relationships among choice, preparation, accountability, and reward (2).

The public assumes an unreasonable burden when employers substitute nurses prepared for one level of practice to another without appropriate experience or education. The concept of substitutability promotes instability in nursing

staffs and high turnover creates enormous human waste in recruitment, hiring, orientation and termination costs. This month a bill (HR 758) was introduced to extend the provisions of Section 1861e of the Social Security Act to provide a waiver that rural hospitals with less than 100 beds would not be required to employ a RN on all shifts. What is a hospital without registered nurses? At the time when hospitals indicate difficulties in getting registered nurses to work evening and night shifts, it is still very common to offer a differential of 50¢ an hour, or $4 for an 8-hour shift! Hospitals seek a waiver from the RN requirement and unsuspecting patients would be left alone with personnel who have had 1 year or less of formal training. Such an institution is not a hospital. Instead of receiving a waiver, such institutions should be reclassified to be reimbursed as a nursing home.

Substitutability means that a hospital can collect reimbursement for a coronary care unit when in fact none of the nurses have been prepared to carry out the specialized procedures of coronary care. Third party payers must be made to understand that reimbursement for nursing services should be separated from an institution's other per diem costs so that nursing charges can reflect appropriately the level and intensity of service actually provided. Nursing costs represent 40-60 percent of the hospital's per diem charge and nursing care represents the reason for hospitalization. If the patient didn't need 24-hour nursing care, ambulatory service could have been provided. There is too much money involved not to require hospitals to furnish a separate breakdown of nursing costs. This would also open the way for the hospital to bill separately for nursing services. This would give consumers an opportunity to relate nursing care to nursing charges and would make Departments of Nursing more accountable.

There is no need for a crystal ball to predict that reimbursement for nurses' services is THE issue for the next decade. I believe the goal of many nonphysician provider groups is to break the economic monopoly of medicine in the provision of health system services. The only way to reduce health care costs is to educate the consumer to make choices, to permit him to do so, and reward him financially for making less costly choices. Highly trained physicians are overprepared in the biological sciences and underprepared in the behavioral sciences for 50 percent to 75 percent of the clients seen in their offices. Clients need the physician's level of competence when acutely ill, but it is too costly a service and an inappropriate service for many of the conditions for which the public seeks relief. In a paper I gave at the Academy of Nursing last fall, I proposed this principle:

> Reimbursement for health care services should be based not only on the nature of the activity performed, but also upon the judgment and competencies of the practitioner which can be brought to bear when performing that service. For the service to be cost-effective, it should be performed most frequently by the least expensive personnel equipped to provide that service in a safe and effective manner (9).

In the beginning of this paper I called for a new Surgeon General's Report to be prepared by a consultant committee, to guide the development

of public/professional relationships in nursing. The main thrust of the 1963 report was nurse manpower. Today, I believe the greatest need is for policy guidance for reimbursement for organized nursing services. Neither taxpayers nor care recipients can afford the present system. Nursing, with the help of the U.S. Congress, must make it clear that there are alternatives.

Jessie, in the tradition of many retired governmental officials, I hope you will become a consultant to the Washington office of the American Nurses' Association.

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TOWARD 1999: PROBING ETHICAL DILEMMAS IN NURSING'S FUTURE

Mila A. Aroskar, Ph.D.

> The future enters into us, in order to transform itself in us, long before it happens.
>
> Rainer Maria Rilke

Nineteen hundred and ninety-nine is just 2 years before the year 2001. You may recall the image of the fetus floating in space in the film by that name. One might speculate that nurses and others will be practicing one day in living environments suspended in outer space dependent on technology in ways only envisioned today by futurists and space scientists. Allocation of nursing resources may take on dimensions not considered in today's world. In consideration of future ethical dilemmas in nursing and health care, we are inquiring systematically into what should or ought to be for nursing: the individual nurse, the profession in relationship with other health workers and patients/clients. An underlying assumption of this paper is that a nursing ethic for the 21st century is just beginning to emerge.

The future emerges from interaction between the forces of rapidly changing technologies in health care, social, professional, and personal values, and the law. One characteristic of the future is that of uncertainty. Researchers of futures suggest that the major objective in looking ahead is generally to explore and examine possibilities that we may want to promote, avoid, or accommodate if they cannot be changed (1). Prediction is not an objective of those who systematically look toward the future. Rather one considers the different paths we might travel through identifying and examining alternative futures or creating various scenarios or models. One looks at key areas which are precursors or warnings of particular futures and articulates preferences clearly--a challenge for the nursing profession today as it has been in the past. Choice is inevitable and necessary. By whom will choices be made and what are the choices we ought to make?

The biomedical health care world is changing rapidly and altering our traditional understanding of human life. Who or what will nurses and nursing be caring for in the future? Will nursing be carried on by people or machines in health care? Some of the current ethical issues and dilemmas confronting us as nurses in education, research, or service and as members of a technologically sophisticated society serve as indicators of the future that will be the present in only two decades.

Major ethical issues throughout the life cycle most likely to be of concern in the foreseeable future and in various stages of resolution have been identified by Thomas McFaul, a sociologist and futurist. They are sanctity versus quality of life, informed consent, determination of participation in biomedical and health care decisions, and the formulation of comprehensive social policy related to those issues (2). Examples of these ethical concerns were identified by the ANA Committee on Ethics just last year. These concerns include rights of children particularly in relation to informed consent, the nurse's obligations with respect to child abuse, development of the hospice concept with implications for changes in ethical considerations of addictive substances, the relationship in practice between the ANA Code for Nurses and State nurse practice acts, and the nurse as an advocate for the patient (3).

The issue of sanctity versus quality of life is reflected in the debate about "humanness" and "personhood" (4,5). The question of when does biological life begin or cease to be human life underlies justifications of abortion, euthanasia, and genetic manipulation, i.e., the conscious attempt to modify in some way the genetic foundation of human life. For example, does human life begin at conception so that one is entitled to certain human and moral rights or does one have to exhibit other psychological, cultural, intellectual or "relational" characteristics to be considered a human person? Perplexing questions and concerns of this nature have profound implications for nursing and society not only in terms of individual decisionmaking but in terms of nursing policy and social, public policy.

The area of informed consent speaks to rights of patients in treatment programs and human subjects in research. Participation must be voluntary and based on adequate knowledge of the nature and possible consequences of the program or the experiments in order to make a reasonable judgment about one's participation. All of the thorny issues of informed consent are involved in confidentiality, truth-telling, behavior control, artificial insemination, experimentation on children and the aged, or participation by the professional nurse in certain experimental situations. Nurses and nursing students in classes and workshops have talked to me about their concerns in all of these areas. Particularly in the area of nontherapeutic research, the conflict of social welfare versus individual interests is most obvious.

The third major area and perhaps the most controversial has to do with determining who can legitimately participate and how in bioethical decisionmaking, since having technical and professional expertise is not necessarily having expertise in moral and ethical questions. Other questions relate to who decides when patients or human subjects cannot decide and who decides when the decision to be made affects the lives of others who are related to or dependent on the patient or human subject. Efforts to develop guidelines for orders not to resuscitate and public discussion of the nurse's moral right and even obligation under certain circumstances to tell the truth to terminally ill patients probe ethical questions around nursing autonomy and interdependence in the decisionmaking process (6). Such discussions are precursors of and suggest choices for the present and futures of nurses and nursing both professionally and organizationally.

The need for biomedical policy, and nursing policy as a subset of such policy, becomes more evident as we struggle with ethical decisions in individual situations which we may or may not wish to universalize but which have implications for all of society, for example, whether or not to lie for someone else, or dealing with requests for euthanasia. The need is critical in regulating activities in such areas as genetic screening and manipulation, in vitro research, euthanasia, and resource distribution in order to monitor potential abuses by those who use and control powerful new technological forces affecting delivery of health and nursing care. Another aspect seldom addressed in discussion of ethics and policy is our interdependence with others in the world who have different ethical and moral concerns related to starvation, communicable disease, and bare subsistence economies. Our futures, too, are interdependent.

Underlying all of these issues is our notion of justice, i.e., the equitable distribution of burdens and benefits in society. Justice is particularly critical in policy issues which are dependent upon the ethical and political context of changing biomedical practices. We desperately need a theory of justice in order to make health care policy. Focusing on justice is not to ignore the importance of respect for the individual, responsibility, and beneficence.

At present, there is no general consensus on what constitutes justice in nursing, health care, or society. Yet some concept of justice, whether conscious or unconscious, whether justice for nurses, the nursing profession, or for our patients and clients pervades decisionmaking at all levels of health care. For example, notions of justice, in addition to economics, etc., underlie the man/womanpower concern in nursing. And the ANA Code for Nurses states that nursing care should be based "solely" on need, one concept of distributive justice.

Distributive justice has to do with what society owes the individual. Other notions of justice are compensatory and retributive justice. Compensatory justice has to do with what one is owed for having suffered past injustices. Retributive justice refers to punishment, i.e., what the individual owes society for past misdeeds or behaviors of a particular kind. Examples of retributive justice may be seen in the treatment of some vulnerable groups such as the mentally ill. An example of compensatory justice in the health care system, although not generally articulated in this manner, is the attention being paid to older Americans and to the disabled in terms of their health care.

Four ideas of distributive justice which have profound implications for nursing and social policy now and in the future are justice based in merit, need, equity, or fairness. They influence how we answer the question, "Who should have nursing care when not all can have nursing care?" For example, in nursing, should our man/womanpower be distributed in the larger community and in community institutions on the basis that some people are more deserving of our care because they can pay for service or they have more "social worth" as breadwinners or administrators of complex bureaucracies. Or, should we articulate nursing policy related to distribution of nursing resources based on some notion of equity which says that people in similar situations should

be treated similarly, not necessarily exactly the same. Equity, as a basis for care, sounds less problematic perhaps than merit. Yet one might ask as to what counts as similar situations when a community nursing agency has limited resources and has identified more than one vulnerable population group in their community, e.g., chronically ill persons at home, dying persons who wish to be at home, and an increasing rate of teenage pregnancies. Are these individuals and groups similar in terms of the need for nursing service?

The concept of need is stated in the ANA Code as the sole basis for distribution of nursing care. A significant challenge here is to sort out demand versus need and who should identify need, i.e., nursing, the client, or the community. This is an issue of the decisionmaking process and involves the predominant attitude of paternalism in health care today, which is being challenged by the consumer movement and self-help groups.

The notion of justice as fairness suggests that all should benefit from a policy with the disadvantaged in society serving as the major consideration. Veatch argues that justice could better be served by taking a position that priority in funding, research, and services should go to the diseases or disease combinations that create the most suffering or hardship (7).

In all of these notions of justice, one clearly sees the tension between the rights of the individual and the rights of others in society. Nurses, as people in special relationships at the interface between patients/clients and others, and with many sources of accountability, live this tension and conflict in daily practice. Nurses deal directly or indirectly with suffering and work to minimize or prevent it in the present and future.

One of the ethical concerns in the present which influences paths we will travel in the future is related to whether nursing can decide in isolation that need will determine whether or not one will receive nursing care? Or if this is a desirable goal, then what policies do we have at present and at what system levels to achieve this goal? In looking at policy development or change in policy, there are other major ethical issues than the underlying concept of justice. These relate to: (1) the choice of goals of the policy which maximize certain values and minimize others; (2) the definition of the target of change whether it is individuals such as nurses or patients or their environment, i.e., the organizations in which nursing care is delivered; (3) the means chosen to implement the policy, e.g., coercion or facilitation; and (4) consideration of direct and indirect consequences of a new policy or change proposed (8).

Examination of ethical dimensions of policy and proposed legislative and court actions raise issues around not only what we can do technically and economically but what we should or ought to do in developing a "just" health and nursing care system for both providers and consumers. Such discussions and decisions take place in what Reinhold Niebuhr called the "twilight zone." This is the realm of politics where ethical and technical issues meet, a realm familiar to all in the nursing community who have struggled for reform and change in the delivery of health and nursing care throughout the history of modern nursing. If need is to be the underlying concept of justice in delivery of nursing care, then policy and laws affecting delivery of nursing care to

people should be put to this test. The answer to what is "just" nursing for individuals, groups and communities can be answered only with open discussion of some very uncomfortable and ambiguous issues such as what are the responsibilities and obligations of nursing to those we claim to serve?

In considering today's ethical dilemmas as forces for forecasting, one might want to think in terms of whether these same dilemmas will actually exist in 20 years, when new exotic issues are constantly being pushed to the forefront by the media and others. On the one hand, one is reminded of issues related to truth-telling or the difficulties of being ethical in existing social and economic structures. These issues and others have existed for the past 2,000 years. One can point to social developments, e.g., codes such as the Nuremberg Code after World War II and legislative and court actions which seek some social consensus around ethically troubling issues. There is the Supreme Court's decision on abortion, decisions around euthanasia, and the right to refuse treatment. There are legislative actions such as the Uniform Anatomical Gift Act, creation of the National Commission for the Protection of Human Subjects and further legislative efforts related to fetal research, genetic screening, claims of rights to refuse treatment and to die with dignity. Such efforts seem to be representative of preventive and public ethics which deal with pressing issues of concern to society, issues which need decisions, and involve ethical and value concerns. They seek to prevent abuses, and support what society considers to be more ethical behavior on the part of individuals, groups and communities.

These actions suggest that there are ethical dilemmas which can and should be approached not only from the individual responsibly struggling with an ethical decision as to what should be done in an individual situation but also from the broader professional and societal viewpoint. Specific situations can be considered as to their implications for policy and the public welfare and proposed legislative and policy actions should be considered in light of their possible consequences for the individual, an ethical consideration. In addition to explication of the economic, legal, and social "facts," the moral values and principles also need to be considered as they influence how one deals with the so-called facts. Discussions and decisions cast in this light have primary, secondary, and tertiary preventive benefits for individuals and groups who are presently agonizing over today's ethical issues and dilemmas in health and nursing care delivery. Will nurses struggling with what is ethical behavior in relation to unwritten "no-code" orders today still be dealing with these issues in 20 years, or can policy be developed to relieve the individual of this burden or to make it a shared burden?

Nurses have the power within ourselves as individuals and within the professional community to deal with our ethical dilemmas of the present in order to influence what our future will look like. Do we have the courage to make individual, professional, curriculum, and organizational changes and to support research which will transform nursing of the present and future to help insure a more humane unfolding of that future? What possibilities do we wish to promote or avoid in nursing's future? How and whether we deal with present ethical issues in nursing does influence our future.

A footnote from a nursing student: "I never realized how important ethical issues are and how much involved in nursing. It is in a way frightening. I hope that when I am a nurse I will be able to deal with these dilemmas." She will probably be nursing in 1999. Will she be nursing a cyborg or a clone and where? What will be the price of ethical behavior on the nurse's part in 20 years?

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PROSPECTIVES FOR NURSING
SOCIAL AND ECONOMIC ISSUES

Luther Christman, R.N., Ph.D.

The growth of the social and economic elements of the health care system of our country has been tied closely to or been a direct outcome of the growth of science and technology. Nurses graduating this year will be near the peak of their careers in 2010. Not even the most gifted can speculate fully on the state of science and technology at that time. If, however, the half life of scientific theory and content is about 2 years at present, in 2010 we may be nearing a stage of instant obsolescence of knowledge. This stark possibility is a concept of such magnitude that it cannot be ignored in planning for the future. A format for nursing education and a delivery system for nursing care that are capable of adapting to the realities of 30 years hence are the only safeguards against a complete deterioration of the profession. We cannot afford to be negligent in mustering resources to accomplish both objectives in such a sophisticated fashion that the expression of the full potential of the profession is continuously facilitated.

A chief criterion by which the social worth of a profession is evaluated is how expertly the rich storehouse of science is made available to society. The form of education, the structure of the profession and the intensity and lengths of career commitments are all indicators of the potential for achieving high marks for social worth.

One reason that the nursing profession lags in this crucial contribution is the nature of its origin. The matron-militaristic model was imported from abroad and, unlike other major professions, it was not transformed by the cultural influences of a democratic scientific culture. In England, the profession was a social isolate, removed from the mainstream of education and preparation for the major professions, and that pattern persisted in this country. The comparatively small number of university graduates in the nursing profession is quantifiable proof of this persistence. Unfortunately, this isolation developed an attitude of introspection which compares nurses qua nurses instead of nurses qua the other health professionals. This attitude has tended to produce a lethargy of growth in the clinical power of nursing as compared to the other clinical professions that have readily adapted to university preparation.

It is a truism that no one can use knowledge he/she does not have. It is impossible for nurses, no matter how oriented they are to humanitarianism, to make the full richness of science useful to patients without a strong knowledge link to that gigantic storehouse. All nurses reach a plateau in scientific sophistication at their individual level of education. All clinicians, no matter which profession, are applied scientists. Thus nurses

have a substantial need to increase their command of all the fundamental sciences required to be effective utilizers of science. Knowledge by itself, however, is not enough. What is needed is the imaginative use of science in every patient encounter. To perform this process in its most elegant fashion, the care of each and every patient should be seen from the viewpoint of both the clinical investigator and the applied scientist. The clinical power that grows from this approach is an entirely different order than that which generally pervades nursing practice. It is a process akin to that used in dentistry, human medicine, veterinary medicine, clinical psychology, and podiatry. The only hope for nurses to perform this process well is one which hangs on the decision that would require all nurses to possess a scientifically rich education. By itself this requirement is insufficient; it is also necessary that the largest proportion of nurses enter graduate study at the doctoral level. All nurses, before 1995, must achieve doctoral scientific competence or else the profession will remain at a pedestrian pace in its social utility.

Utilizing a few indicators of the social scene may enable us to come to grips with the issues in an orderly fashion. At present, many nurses are divided on the issue of unionism. For purposes of this presentation unionism will be any condition where collective bargaining and work contracts are the negotiating processes for workload and reimbursement purposes. No evidence suggests that the presence of unionism facilitates professional development. There is, however, some suggestive evidence to the contrary. The teaching profession is a case in point. The definite shift of public attitudes toward teachers since unionization and strikes have become major devices for fixing economic return and working conditions should be an alerting signal to nurses. The spread of unionization to community and upper division colleges seems to be producing the same shift of negative attitudes. The New Zealand nurses are an excellent example of overunionization. Because the largest enrollment in union membership comes from staff nurses and students, the primary attention of union activity is focused on these two groups. The economic gap between the rewards for upper levels of nurses as contrasted to lower levels is relatively narrow. As a consequence, career orientations are blunted and professional growth stunted. Although these nurses are caught additionally in the web of a fully nationalized health care system, the unionization of the profession has interfered greatly with the educational and professional development of nurses.

It seems better for nurses to look toward developing forms of self-governance to ensure their professional destiny. This form of organizing should be similar to that employed by dental and medical staffs, to that generally used by university faculties, or to that utilized by organizations of research scientists. Responsibility and accountability for establishing standards, controlling practice privileges, enforcing audit review, and when necessary, invoking negative sanctions where professional shortfalls occur, are signs of full maturity in a profession. Until and unless nurses undertake this venture, their full power for constructive action for social usefulness is limited.

National health insurance and its influence on developments within the profession are other imponderables. The effect of such an occurrence probably will be modified according to the direction that nurses can achieve by

the time full entitlement to health care is enacted. Although legislation has been proposed and introduced fully to nationalize health care from the time of my days as a nursing student to the present, the Federal management of health care has not been achieved. Nevertheless, the delivery of health care as a public utility has become almost a reality. The enormous amount of legislation regulating health care, the constant shifts in support of programs, the strictures of cost containment, the ebb and flow of reimbursement methodologies, and the vagaries in funding health manpower development are complexities of the system that tend to bring closure to options. The best means of avoiding a rigid entrapment of the present system is to move the education of nurses into university medical centers, to abandon all other educational settings, to reorganize nursing services to focus on clinical excellence and thus enrich the nursing care of patients, and to launch research designed to improve the quality of nursing practice. A profession has to be prepared beyond the level of the current scene to be opportunistic when breakthroughs occur.

The present rapid shift in emphasis on first encounter care will have many unintended consequences. One of these is a shift in the training of physicians. No longer will hospitals have the large variety of house officers. As residencies are phased out, the clinical work assigned to their role will have to be done by others. Nurses, in collaboration with physicians, have an unusual opportunity to redefine the care interface between physicians and nurses at new levels of abstraction. This endeavor would, in all liklihood, catalyze a liberalization of present practice laws. Many productive variations on the theme of interdisciplinary collaboration would be possible. These concepts would have a natural extension to primary encounter care arrangements. If this enterprise is undertaken, it will create an enormous demand for doctoral preparation. True interdependent relationships do not occur out of incompetence. Thus, the level of clinical expertise will be insufficient if it plateaus for nurses at the master's level; it will have to be based at the doctoral level to keep pace with fellow colleagues in the other clinical professions. Economic rewards for providers will be keyed increasingly to the value of their services and achieved expertise in facilitating health goals of individuals and the public in general.

The presence of high complex technology will have fallout effects on all clinicians. Computer-assisted patient care will be a commonplace tool. Quality assessment and quality control will become sophisticated and very accurate. Audit will be a continuous process; thus clinical decisions will have to be made with more precision because surveillance will be instant and constant. Licensure renewal probably will depend on how well one continues regularly to perform clinically, measured by national norms rather than by devices such as continuing education. But the use of computer-assisted practice is not all onerous. Computer-assisted practice will enable richer data bases for clinical action, more easily conducted clinical research, and better interdigitation of the various types of clinicians who are assisting in the care of each patient. The mastery of the technology is the issue, not its presence.

The democratization of work in general and the professions in particular will continue until the ultimate is obtained. In the process of the

disruption of sex-linkage to career patterns, there will be a brain drain from the historical women's professions because of the easier access to the traditional men's professions. The number of bright women selecting the nursing profession will decrease. To fill this gap, an intensive and extensive effort to recruit an equal number of bright men will have to be made to keep the intellectual base of the profession at competitive levels with the other professions. The full democratization of the nursing profession is a prerequisite in the competition for bright minds and poses a question of whether or not the women's professions will have the foresight or be willing to accommodate to this required change.

One can only be suggestive about the many other economic and social possibilities of the future. As a start, it is safe to say that out-of-hospital care will receive as much or more emphasis as hospital care receives now. All kinds of day, evening, and partial hospitalization will be introduced; health management programs will take on new texture; industrial health programs will be of a new order; psychiatric care will undergo huge transformation; international health programs will become a critical necessity because of global trade and travel; the geriatric population of not only this country but the world in general will be of an enormous size and the emphasis on health care activity will shift proportionately. Because all the quick killers virtually are eliminated, there will be an increasing emphasis on the management of chronicity and on effective rehabilitation.

Given the work to be done, the training and development stage of nursing appears puny and not in good posture to move with the times. Among the urgent immediate tasks is raising the level of preparation of university nursing faculties to the same level as the remainder of the university faculties. The pedestrian pace of doctoral production is not enough if we must assemble faculties capable of producing the nurses of the future. At least 10 percent of all nurses now practicing will, in the near future, have to earn doctorates to form the critical mass needed to handle all the educational and delivery programs that will undergo exponential increases in complexity. That number is roughly 75 times the number of nurses who are now holding doctoral degrees.

The growth rate of the scientific strength of the profession depends on how strongly nurses aspire to making their profession a co-leader with the other health professions in the continuously evolving social scene. To think about the future is a titilating experience; to dream about it is a stimulating flight of phantasy; but to be ready for it is exhilarating.

PROSPECTIVES FOR NURSING
FORCES FOR FORECASTING: BIOLOGICAL-ENVIRONMENTAL ISSUES

Cornelius Kruse, Dr. P.H.

Future directions for nursing in relation to biological and environmental issues may not be what one would normally expect from a public health professional. We could discuss at great length the issues surrounding the hospital environment, which is fraught with many environmental problems of concern to nursing. Or we could discuss other issues such as recombinant DNA, radiation therapy, the host of infectious agents and concerns of immunosupressed patients, cross contamination, and the like. I am going to leave these very sticky issues to someone more knowledgeable of the intricate details involved.

We are supposed to look into the future, to see into the crystal ball. As an engineer I hate to do that, because I can make so many mistakes. Engineers, like surveyors, tend to look behind them now and then to see what can be learned from the past. The transit is a special instrument used for projecting a straight line. The viewer looks through a telescope at pegs set behind him and plunges the instrument 180^{0} in the opposite direction. In this manner we plunge straight ahead into the problems and issues that are a great distance down the road. But it isn't wise to plunge too far ahead since this method works well only as long as there are no curves in the road.

In thinking about the future, I like to look behind me because I can learn a great deal from the past. For example, let's think about the biological-environmental issues that existed over 100 years ago, at the beginning of the Industrial Revolution and the first sanitary movement that soon followed. It all began with coal. In England and Germany, influential people who loved to hunt in the forests became sick and tired of the practice of burning up the trees in the forest to make charcoal to provide enough reducing agent to make a little pot of steel from iron ore--sort of on the same scale as a woman working in her kitchen. Someone finally found out that steel could be made by converting coal to coke and, suddenly, the Industrial Revolution began. A variety of enterprises were drawn to the industrial centers, accompanied by large numbers of people from rural, primitive societies who stacked themselves into these industrial cities under the most appalling slum conditions ever seen.

The Industrial Revolution set off a hundred years of chaos, of pestilence and plague. First one experiment and then another was tried, mostly on an empirical basis. Finally, through the development of microbiology, epidemiology, biostatistics, and public administration, the scientific base for needed interventions was found. This public health methodology was not learned overnight, but over many years, and it was important to the efforts made to bring order out of chaos. Promises could be made and fulfilled when recommended

measures were carried out. We need to keep this in mind as we project possible solutions for future problems.

After the Industrial Revolution, we learned how to ensure safe water, decent housing, and sanitation, and to have something in the way of adequate nutrition and medical care. With the success of orthodox public health methods, people were able to live longer. Today we live long enough to "enjoy" the chronic diseases of cancer, heart, stroke, and the like.

And so we move ahead. Now we are into the second industrial revolution, popularly known as better living through chemistry, or the microchemical world. We have manmade chemicals that are far removed from natural ones, drugs, cyclomates, saccharin, fibers, and a host of other products that we apparently can't live without. Many of these emanate from the liquid and gaseous fossil fuel feedstocks, i.e., petrochemicals, just as the Industrial Revolution emanated from coal.

This second industrial revolution is very energy intensive, with less need for human labor; machines do it all. In the United States enterprises are large; large is beautiful. Power plants, petrochemicals, steel plants, fertilizer plants, agribusiness--everything is on a large scale. Again, we have shifting populations, with farm labor moving into the cities to work in the large plants, accompanied by an outmigration to the cow pastures by everybody who can afford it. We call the areas surrounding the cities septic-tank suburbias, with soapy well waters, split-level homes, two cars, and grass, lots of grass (crab grass, that is). In this day and age, it doesn't matter whether you believe in God or not, but you'd better have grass.

There is a tremendous amount of dissatisfaction and honest fear about our environment and biological developments resulting from our second industrial revolution. What are these fears? Mainly we fear the unknown. We don't know all the effects of radiation from nuclear power plants or the long-term results of dumping nuclear wastes. Although we know that we have lived with radiation from the beginning and that the greatest source of radiation to our population is from medical uses, we don't know all that needs to be known. We don't know what our new strange, manmade chemcials will do to our health. Given half a chance, the natural environment adjusts quickly, developing resistance to new drugs and insecticides, and biodegrading these exotic wastes, but it still takes an interval of time to create defenses against these manmade monsters. In the meantime, people want clean air and pure water, along with a guaranteed safe environment and prolonged life expectancy.

The National Environmental Policy Act of 1969 fixed the responsibility for all of this at the Federal level; local and State levels of government were apparently not able to do what was required. Soon there was an avalanche of environmental legislation on clean air, clean water, resource recovery, hazardous waste, toxic substances, consumer protection, to name a few. Why were these laws passed by our Congressmen and Senators? In fact, all these laws probably aren't needed and far outrun our ability to carry them out with any reason or sense. But they were all worked out, with public hearings, procedures, and timetables: 90 days for this, 60 days for that. We have the laws and we should be happy.

The problem is that we are in a period of chaos with a paucity of scientific facts to back up the goals of our laws. We are moving too rapidly. We are setting up standards day after day on little or no scientific base. Actually, the laws mandate that proof of hazard is not a prerequisite to regulate a substance. Have you ever read a criteria document for a toxic substance? If you have, were you convinced that the nature of the risk to health was real? We lack the scientific base to say what "safe" is. We suffer from the notion that easy solutions can be obtained for complex problems by merely spending a little more money.

The interesting thing is that the money is not often being spent in the right areas. Environmental management programs require so much regulation and red tape that business and commerce grow at a slow pace while bureaucracy fattens. Behavior and lifestyle modification having the most pressing public health priority languish.

Paradoxical actions are made all the time in the name of the public's health. For example, all the old, dirty, high sufphur, coal-burning electric stations are forbidden, so that chronic bronchitis and emphysema will be reduced. Although we have never been able to document this benefit, conversion to oil, natural gas, and even nuclear power was the order of the day. So we closed the mines and lost our most abundant resource for energy. You all know what has happened since then. In our state of confusion, we export our coal and import our oil with disasterous worldwide inflation as a result. There is lots of talk about nuclear, solar, wind, wave, biomass and conservation. The plastic world is starting to collapse around us. Our worst enemies wouldn't have made some of the recommendations that we have heard.

The overview of the environmental, economic impact of proposed solutions to our problems are becoming the problem. We can't afford the overkill approach. We need to see the real world around us, to understand that there is 30 percent unemployment in the large cities among young minority group members, to appreciate the fact that infant mortality rates have been creeping up again. We should acknowledge the major role of smoking and work environments in cancer and slack off on ephemeral factors.

Now a look toward the future. For the next several years, we will continue the sanitary movement, but, I hope, not to shooting cannons to abate yellow fever. We are going to fumble, spend money in the wrong places, and create more chaos until we develop a firm scientific base for solving our health problems. We will again need to rely on public health methodology to evaluate the nature of the health risk and evaluate effectiveness of proposed interventions. In other words, the growing variety of regulatory agencies will need to utilize public health methodology to a much greater extent than they have in the past.

I think the current procedure for making rules and regulations related to various new substances needs to be modified. There are too many of them; all are difficult to monitor, and the risk of low level exposure is unknown. We should contain them in manufacture and utilization to the best of our ability until human evidence is accumulated.

Nor do we need to be ashamed of the practice of lowering limit values as we learn more. For example, in the 1930's, the safe threshold level for benzene was at 100 parts per million. Later it was lowered to 50 parts per million. After World War II, it was cut to 25, then to 10, and most recently, due to suspected carcinogenic properties, the threshold level may be cut to 1 part per million. What happens to those who, 30 years ago, were not violating the law in use of substances, but who are now threatened with law suits by people claiming they received cancer exposure in their workplace? Industries willing to turn over their records for epidemiological study may get off the hook, whereas others may be doomed. This is a difficult legal and moral problem that as yet has no solution.

It is easy to forget the problems of the Third World. Not every country has conquered communicable disease nor have their citizens lived to appreciate and enjoy our chronic diseases. Many people still struggle with tuberculosis, malaria, schistosomiasis, onchocerciasis, and many other diseases. Other parts of the world are working on basic programs of public health, such as immunization for malaria and gonorrhea, that the Western World take for granted. New toxicology methods, combining animal experiments with model building and computer simulation, allow us for the first time to estimate the risk of low levels of exposure of various substances to our population. These risk factors are useful in standards-setting that includes not only the risk but the cost.

As we foresee future problems and look at our current ones, it is evident that shortages are going to develop, that lifestyles will eventually have to change, and that our methods for solving our problems will undoubtedly change. We know that we can, today, contribute to the Nation's health by not eating too much, not drinking too much, not smoking too much, and by exercising more. We know that our problems will not be solved by a 90 day "this" or a 60 day "that," but that biological-environmental changes that benefit the health and welfare of people takes great effort. Lasting progress, we must recall, is not the result of crash programs, but decades of good solid work.

PROSPECTIVES FOR NURSING
FORCES FOR FORECASTING: ORGANIZATIONAL ISSUES

Dorothy J. Novello, Ph.D.

The charge to this panel was to consider each specific, assigned topic as it relates to the growth of the nursing profession. Organizational issues is an extremely broad topic since, by definition, an organization may be formal or informal, simple or complex. For purposes of discussion today, I elected to consider only one organization, the health care delivery system.

"It was the best of times,
It was the worst of times.
It was the age of foolishness
It was the epoch of belief...

It was the season of Light
It was the season of Darkness
It was the spring of Hope
It was the winter of Despair

We had everything before us
We had nothing before us."

These lines from Charles Dickens' A Tale of Two Cities very aptly describe the current state of the health care delivery system in this country. Never before in the history of mankind has health care offered such great hope for the alleviation of human suffering, and at the same time offered a delivery system so rife with turmoil and complaint. In truth, there is only one core organizational issue involved. Simplistically stated, the issue is how to deliver quality health services to all segments of the population at an affordable cost. Suggestions to resolve this issue are voluminous and, so far, have resulted in some legislation, considerable rhetoric, and minimal results. A truly complete model for health care delivery is, of necessity, extremely complex and has, to date, defied all attempts to estimate cost.

Yet the current system, or lack of a system, is touted as being "costly" and absorbing "too much" of this Nation's growth capital. In 1980 Americans are expected to spend about $229 billion on health care. All told about 9 percent of the gross national product or 1 dollar out of every 11 spent in the United States today. In addition to the criticisms leveled against cost, dissatisfaction concerning the quality of care being paid for is expressed equally. Both are important.

A number of health care systems models have been proposed and attempts have been made to deal with separate components of the issue through

legislation, i.e., professional standards review organization (PSRO) are charged with judging quality of medical care and its appropriateness, while certificate of need legislation (CON) is designed to assure the need for existing, expanding, and/or developing health care services.

Since outlays for hospital care amount to 40 percent of all health spending by the public and government, hospitals have come under the closest scrutiny in recent years. Crippled by inflation and badgered by criticism, the hospital industry is scrambling for economic survival. Cost-constraint, overbedding, tighter utilization controls, capital needs, exploding new medical technologies, reimbursement strategies, and tax policy make it increasingly difficult to maintain a freestanding hospital. Many authorities question the continued viability of single, freestanding, separately managed hospitals over the next 10-20 years. A variety of new organizational arrangements, shared services, condominiums, consortia, mergers, regional multiunit hospital systems, and national chains have emerged to facilitate systems integration. A persistent issue as systems of hospitals emerge will be the struggle between uniformity and diversity, between centralization and decentralization. Our culture carries a very strong interest in decentralization and community control, especially in relationships to medicine and hospitals. Regardless of choice, it seems inevitable that hospitals will merge into corporations, and administrative personnel in such structures will have to be well grounded in economics, information systems, accounting, financing, marketing, regional planning, law, and politics. In an attempt to avoid further governmental regulation, hospitals have mounted a voluntary program to contain rising cost.

In spite of these efforts, it is all too clear to even the most naive that health care in this country must move beyond the services offered by secondary and **tertiary organizations.** The need for primary health care services has received considerable attention over the past 10 years and Federal support has been provided to a variety of organizational systems that focus on this option. One of the more acceptable systems to emerge is the health maintenance organization (HMO). HMO's are designed to deliver a comprehensive range of services through a prenegotiated and fixed periodic payment plan by a voluntarily enrolled group. Although HMO's have met with less than spectacular success, the current move to interest industrial corporations and organized labor in HMO's portend well for their future. The most radical shifts in health care delivery over the next 10 years will be brought about by large industrial corporations. Industrial corporations will become prime deliverers of health care because, second only to the Federal Government, they are the prime payers for health services. Corporations recognize that they can no longer afford to continue to extend "sick benefits" to their employees. They are also convinced that in the long run primary services that stress preventive, promotive, and maintenance health care will provide them with healthier employees at reduced cost. Industrial corporations are accustomed to identifying and resolving problems that deplete profit margins. As they become increasingly disillusioned about the ability of government to produce the changes necessary, they will move in to become their own health care delivery systems.

Just as imminent is the reemergence of revitalized school health programs. Such systems for delivering health care still offer the best opportunity for raising the health index of this country. There are many who question the use

of educational systems for delivering health care, but if past achievement is any measure for future success, preventive/promotive health care services for children have reaped a remarkable harvest. The fact that we have an aging population is more directly related to having survived or circumvented the illnesses of childhood than any other "miracle" of modern day medicine.

Other efforts to address the issue of accessible and affordable quality health care are effective in varying degrees and are making some mark on emerging concepts for improving health care delivery. Emergency medical services, ambulatory care services, long-term care services, home health care services, health education, hospices, group practices, the Kaiser Permente Plan, all of these are attempts to provide an answer to a very complex problem. Health Systems Agencies (HSA's), designed to do the groundwork prerequisite to the passage of a national health insurance plan, have failed to effect the changes planned. They have been tangled in bureaucratic tape since their inception and the future does not seem too bright. Consumer members of HSA's have proved to be just as protective about duplicating health care services as providers are. Local planning, which sounds good in theory, in actuality is riddled with politics and self-interest. Whether or not HSA's have even an equal chance to realize their potential is difficult to predict. To change the total health care delivery system is a horrendous task and the best that we have been able to do is some "blind tinkering" with the existing system.

How will these attempts to resolve the issue of delivering quality health care to all segments of the population at an affordable cost effect growth in nursing. Hopefully, <u>not at all</u>, if one equates growth with change in role. Extensively, if one equates growth with utilization of the specialized expertise that professional nurses can contribute to health care delivery. The tendency to link the practice of professional nursing to health delivery systems is disastrous to the development of the nursing profession. In constantly responding to present or emerging health care delivery systems, nurses will continue to be chameleons, changing and adpting their practice dependent upon the whims or gaps in the organizational system involved. Nursing can not continue to define its practice on the basis or organizational patterns of health care delivery, whether such patterns be dictated by the walls of highly sophisticated teaching hospitals or the open skies of Indian reservations. The practice of professional nursing must be constant wherever it is practiced. Since people are the primary target system for nursing, the "care" that professional nurses deliver may change but only in direct response to the health care needs of people, not organizations. From decade to decade the health care needs of people may vary, dependent upon a whole host of factors, some of which have been discussed today. A valid nursing model allows for the diversity necessary to remain sensitive to a people-centered practice profession. The continued effort of health delivery systems to adapt and to search for newer, more economical delivery systems will influence the growth of nursing to the extent that nursing seizes the opportunity to clearly define its scope of practice and to "sell" its expertise to consumers. The consumer is uncertain about what nurses do, because far too many nurses are not certain of their own identity. The task of assisting vast numbers of nurses in the process of self-realization is difficult and perhaps impossible. The professional stature that nursing seeks will remain elusive until the public is very

much aware of what nursing means. Physicians, dentists, podiatrists, chiropractors, and veterinarians are well recognized by the public on the basis of the service that they deliver. Not so with nurses because nurses have yet to agree upon the uniform nature of their practice.

I am not a pessimist by nature. I am an optimist and perhaps an idealist. John Ralston once said, "Any thing you can vividly imagine, ardently desire, sincerely believe in, and enthusiastically act upon must inevitably come to pass." Do you suppose that nursing's imagination, desire, convictions, and enthusiasm will influence the growth of nursing over the next 20 years more so than organizational issues? I HOPE SO.

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